Policy Statement

Ultrasonographic measurement of carotid intima-media thickness (CIMT) as a technique for identifying subclinical atherosclerosis is considered investigational for use in the screening, diagnosis, or management of atherosclerotic disease.

Policy Guidelines

The following CPT category I code specific to the combination of carotid intima-media thickness (CIMT) and carotid atheroma evaluation:

- **93895**: Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral

The following CPT category III code specific to this test:

- **0126T**: Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment

Description

Ultrasonographic measurement of carotid intima-media (or intimal-medial) thickness (CIMT) refers to the use of B-mode ultrasound to determine the thickness of the 2 innermost layers of the carotid artery wall, the intima and the media. Detection and monitoring of intima-medial thickening, which is a surrogate marker for atherosclerosis, may provide an opportunity to intervene earlier in atherogenic disease and/or monitor disease progression.

Related Policies

- Computed Tomography to Detect Coronary Artery Calcification
- Novel Biomarkers in Risk Assessment and Management of Cardiovascular Disease

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

In 2003, SonoCalc® (SonoSite) was cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. The FDA determined that this software was substantially equivalent to existing image display products for use in the automatic
measurement of the IMT of the carotid artery from images obtained from ultrasound systems. Subsequently, other devices have been cleared for marketing by the FDA through the 510(k) process. FDA product code: LLZ

**Rationale**

**Background**

**Coronary Heart Disease**

CHD accounts for 30.8% of all deaths in the U.S. Established major risk factors for CHD have been identified by the National Cholesterol Education Program Expert Panel. These risk factors include elevated serum levels of low-density lipoprotein cholesterol, and total cholesterol, and reduced levels of high-density lipoprotein cholesterol. Other risk factors include a history of cigarette smoking, hypertension, family history of premature CHD, and age.

**Diagnosis**

The third report of the National Cholesterol Education Program Adult Treatment Panel established various treatment strategies to modify the risk of CHD, with emphasis on target goals of low-density lipoprotein cholesterol. Pathology studies have demonstrated that levels of traditional risk factors are associated with the extent and severity of atherosclerosis. The third report of the National Cholesterol Education Program Adult Treatment Panel recommended use of the Framingham criteria to further stratify those patients with two or more risk factors for more intensive lipid management. However, at every level of risk factor exposure, there is substantial variation in the amount of atherosclerosis, presumably related to genetic susceptibility and the influence of other risk factors. Thus, there has been interest in identifying a technique that can improve the ability to diagnose those at risk of developing CHD, as well as to measure disease progression, particularly for those at intermediate risk.

The carotid arteries can be well-visualized by ultrasonography, and ultrasonographic measurement of the carotid intima-media thickness has been investigated as a technique to identify and monitor subclinical atherosclerosis. B-mode ultrasound is most commonly used to measure the carotid intima-media thickness. The intima-media thickness (IMT) is measured and averaged over several sites in each carotid artery. Imaging of the far wall of each common carotid artery yields more accurate and reproducible IMT measurements than imaging of the near wall. Two echogenic lines are produced, representing the lumen-intima interface and the media-adventitia interface. The distance between these two lines constitutes the IMT.

**Literature Review**

Evidence reviews assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these reviews, and credible information on technical reliability is available from other sources.

The literature on the use of carotid intima-media thickness (CIMT) for cardiac risk stratification consists of numerous cohort studies and systematic reviews of these cohort studies. The following review includes the largest prospective cohort studies and the most important systematic reviews of these studies.
Ultrasonographic Measurement of Carotid Intima-Media Thickness

Because different specialties may use different terms for the same concept, we are highlighting the core characteristics. The core characteristics also apply to different uses of tests, such as diagnosis, prognosis, and monitoring treatment.

The approach and metrics for assessing each of the core characteristics are described below.

Clinical Context and Test Purpose

The purpose of ultrasonic measurement of CIMT is to provide a diagnostic option that is an alternative to or an improvement on existing tests, such as standard of care and alternative cardiovascular risk predictors, in patients who are undergoing cardiac risk assessment.

The question addressed in this evidence review is: Do the results of ultrasonographic measurement of CIMT improve risk categorization in individuals who are undergoing cardiac risk assessment?

The following PICO was used to select literature to inform this review.

Patients

The relevant population of interest is individuals who are undergoing cardiac risk assessment. This population may have other risk factors for coronary heart disease (CHD), including a history of cigarette smoking, hypertension, family history of premature CHD, and age.

Interventions

The test being considered is ultrasonic measurement of CIMT. Ultrasonographic measurement of CIMT refers to the use of B-mode ultrasound to determine the thickness of the 2 innermost layers of the carotid artery wall, the intima and the media. Detection and monitoring of intima-media thickening, which is a surrogate marker for atherosclerosis, may provide an opportunity to intervene earlier in atherogenic disease and/or monitor disease progression.

Patients who are undergoing cardiac risk assessment are actively managed by cardiologists and primary care providers in an outpatient clinical setting.

Comparators

Comparators of interest include standard of care and alternative cardiovascular risk predictors. Standard of care includes hypertension/blood pressure control and regular screenings. Alternative cardiovascular risk predictors commonly refer to the Framingham Risk Score, a gender-specific algorithm used to estimate the 10-year cardiovascular risk of an individual. The Framingham Risk Score was first developed based on data obtained from the Framingham Heart Study, to estimate the 10-year risk of developing CHD. In order to assess the 10-year cardiovascular disease risk, cerebrovascular events, peripheral artery disease, and heart failure were subsequently added as disease outcomes for the 2008 Framingham Risk Score, on top of CHD.

Patients who are undergoing cardiac risk assessment are actively managed by cardiologists and primary care providers in an outpatient clinical setting.

Outcomes

The general outcomes of interest are test accuracy and morbid events. Possible negative outcomes include stroke, myocardial infarction (MI) and heart failure.
Table 1. Outcomes of Interest for Individuals Who Are Undergoing Cardiac Risk Assessment

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Details</th>
<th>Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test accuracy</td>
<td>Evaluating the efficacy of CIMT in assisting in estimation the risk of cardiovascular disease using tools such as the Framingham Risk Score or the European systematic coronary risk evaluation</td>
<td>1-10 years</td>
</tr>
<tr>
<td>Morbid events</td>
<td>Cardiovascular events (e.g., myocardial infarction, stroke, angina, vascular death).</td>
<td>5-10 years</td>
</tr>
</tbody>
</table>

CIMT: carotid intima-media thickness.

Study Selection Criteria

Below are selection criteria for studies to assess whether a test is clinically valid.

- The study population represents the population of interest. Eligibility and selection are described.
- The test is compared with a credible reference standard.
- If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
- Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (e.g., receiver operating characteristic, area under receiver operating characteristic, c-statistic, likelihood ratios) may be included but are less informative.
- Studies should also report reclassification of diagnostic or risk category.

Technically Reliable

Assessment of technical reliability focuses on specific tests and operators and requires review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review, and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid

A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Review of Evidence

Systematic Reviews

Mookadam et al (2010) conducted a systematic review of the role of CIMT in predicting individual cardiovascular event risk and as a tool for assessing therapeutic interventions. Reviewers concluded that CIMT is an independent risk factor for cardiovascular events and may be useful in determining treatment when there is uncertainty regarding the approach or patient reluctance. However, they recommended further study to identify the best approaches to screening and interventions to prevent progression of atherosclerosis.

In a meta-analysis, the USE Intima-Media Thickness collaboration investigators sought to determine whether common CIMT measurements can assist in estimating the 10-year risk of first-time MI or first-time stroke when added to the Framingham Risk Score. Den Ruijter et al (2012), using individual data for 45,828 patients from 14 population-based cohort studies, found risk of first-time MI or stroke was related positively to both the Framingham Risk Score and the adjusted common CIMT. The mean common CIMT was 0.73 mm, and it increased in every cohort with patient age during a median follow-up of 11 years. For every 0.1-mm difference in common CIMT, the hazard ratio (HR) for risk of MI or stroke, which occurred in 4007 patients, was 1.12 (95% confidence interval [CI], 1.09-1.14) for women and 1.08 (95% CI, 1.05-1.11) for men. However, adding common CIMT measurements to the Framingham Risk Score did not improve risk prediction and resulted in the reclassification of risk in only 6.6% of patients. The added value of mean common CIMT in reclassifying risk was only 0.8% (95% CI, 0.1%-1.6%) and did not differ between men and women. The C statistic of the Framingham Risk Score model with and without CIMT was similar for men (0.759; 95% CI, 0.752-0.766) and women (0.757; 95% CI, 0.749-0.764), suggesting the addition of CIMT in risk assessment offered limited benefit.
Lorenz et al (2012), in another meta-analysis, pooled individual participant data from 16 studies (N = 36,984 patients) and examined CIMT progression from 2 ultrasound screenings taken 2 to 7 years apart (median = 4 years). Patients were followed for a mean of 7 years, during which time 1339 strokes, 1519 MIs, and 2028 combined endpoints (MI, stroke, vascular death) occurred. Mean CIMT of the 2 ultrasound results was predictive of cardiovascular risk using the combined endpoint (adjusted HR = 1.16; 95% CI, 1.10-1.22). In sensitivity analyses, no associations were found between cardiovascular risk and individual CIMT progression regardless of CIMT definition, endpoint, and adjustments. As an example, for the combined endpoints, an increase of 1 standard deviation in mean common CIMT progression resulted in an overall estimated HR of 0.97 (95% CI, 0.94-1.00) when adjusted for age, sex, and mean common CIMT; the HR was 0.98 (95% CI, 0.95-1.01) when adjusted for vascular risk factors. These data confirmed that CIMT is a predictor of cardiovascular risk but did not demonstrate that changes in CIMT over time are predictive of future events.

Van den Oord et al (2013), published a meta-analysis of 15 articles (2013) and found similar results on the added value of CIMT. Six cohort studies (N = 32,299 patients) were evaluated to examine the predictive value of CIMT when added to traditional cardiovascular risk factors. Although a CIMT increase of 0.1 mm was predictive for MI (HR = 1.15; 95% CI, 1.12 to 1.18) and stroke (HR = 1.17; 95% CI, 1.15 to 1.21), the addition of CIMT did not statistically improve risk prediction over traditional cardiovascular risk factors (P = 0.8).

Studies have found that including carotid plaques in CIMT measurements improved the predictive value of cardiovascular risk over CIMT assessed only in plaque-free sites. However, Lorenz et al (2012) found no difference in the main results between studies that included CIMT with carotid plaque and plaque-free CIMT. Peters et al (2012) found in their systematic review that adding carotid plaque to the traditional CIMT model increased the C statistic from 0.01 to 0.06.

### Table 2. Systematic Reviews & Meta-Analysis Characteristics

<table>
<thead>
<tr>
<th>Study</th>
<th>Dates</th>
<th>Trials</th>
<th>Participants</th>
<th>N (Range)</th>
<th>Design</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorenz (2012)</td>
<td>NR</td>
<td>16</td>
<td>Patients who were assessed with CIMT twice and followed up for myocardial infarction, stroke or death</td>
<td>36,984 (297-12,221)</td>
<td>Prospective, longitudinal, observational</td>
<td>NR</td>
</tr>
<tr>
<td>van den Oord (2013)</td>
<td>1997-2011</td>
<td>15</td>
<td>Patients at risk for CV events</td>
<td>76,201 (1,734-14,214)</td>
<td>Observational studies</td>
<td>NR</td>
</tr>
</tbody>
</table>

NR: not reported; CV: cardiovascular; CIMT: carotid intima-media thickness.

### Table 3. Systematic Reviews & Meta-Analysis Results

<table>
<thead>
<tr>
<th>Study</th>
<th>CIMT Progression HR (95% CI)</th>
<th>Association of CIMT with CV Risk HR (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lorenz (2012)</td>
<td>0.97 (0.94 to 1.00)</td>
<td>1.16 (1.10 to 1.22)</td>
</tr>
<tr>
<td>van den Oord (2013)</td>
<td>Association of 1 SD (0.1 mm) Increase in CIMT With Future MI HR (95% CI)</td>
<td>1.26 (1.20 to 1.31)</td>
</tr>
</tbody>
</table>

CIMT: carotid intima-media thickness; CV: cardiovascular; MI: myocardial infarction; HR: hazard ratio; CI: confidence interval; SD: standard deviation.

* When adjusted for age, sex, and mean common CIMT.
Prospective Cohort Studies
Numerous prospective cohort studies have evaluated the association between CIMT and future cardiovascular events. Some of the larger trials are discussed below. For example, in the Atherosclerosis Risk in Communities study, trialists evaluated risk factors associated with increased CIMT in 15,800 subjects. CIMT had a graded relation with increasing quartiles of plasma total cholesterol, low-density lipoprotein cholesterol, and triglycerides. CIMT also correlated with the incidence of CHD in a subgroup of patients enrolled in the trial after 4 to 7 years of follow-up. Among the 12,841 subjects studied, there were 290 incident events. The HR rates for women and men, adjusted for age and sex, comparing extreme CIMT (i.e., ≥ 1 mm) with nonextreme CIMT (i.e., < 1 mm), were 5.07 for women and 1.85 for men. The strength of the relation was reduced by including major CHD risk factors but remained elevated for higher measurements of CIMT. Authors concluded that mean CIMT was a noninvasive predictor of future CHD incidence.

The Rotterdam cohort study started in 1989 and recruited 7983 men and women ages 55 years and older. Its main objective was to investigate the prevalence and incidence of risk factors for chronic diseases, including cardiovascular disease (CVD), in older adults. One aspect of the study sought to determine whether progression of atherosclerosis in asymptomatic elderly subjects is a prelude to cardiovascular events. Measurements of CIMT were used to assess the progression of atherosclerosis. Increasing CIMT was associated with increased risks of stroke and MI.

O'Leary et al (1999) performed CIMT measurement on 4476 asymptomatic subjects aged 65 years or older without clinical CVD in the Cardiovascular Health Study. The incidence of cardiovascular events correlated with measurements of CIMT; this association remained significant after adjusting for traditional risk factors. Authors concluded that increases in CIMT were directly associated with an increased risk of MI and stroke in older adults without a history of CVD.

The longitudinal Carotid Atherosclerosis Progression Study included 4904 subjects. All subjects received a baseline CIMT measurement as well as a traditional risk factor analysis and were followed for 10 years (mean follow-up = 8.5 y; range = 7.1-10.0 y). Adverse events were MI in 73 (1.5%) patients, angina or MI in 271 (5.5%) patients, and death in 72 (1.5%) patients. Lorenz et al (2010) retrospectively reviewed Carotid Atherosclerosis Progression Study data. They modeled the predictive value of CIMT on the cardiovascular adverse events within that decade. Because the thresholds of CIMT measurements that would lead to reclassification of risk are unknown, the authors used 24 models of reclassification and 5 statistical tests. Each model compared the predictive value of traditional risk factors alone with those risk factors plus CIMT. None of the reclassification models improved with the addition of CIMT measurements. Investigators concluded that their retrospective analysis did not support the use of CIMT as a clinically useful risk classification tool when used with traditional risk factor analysis.

In the Multi-Ethnic Study of Atherosclerosis (MESA) trial, an ongoing cohort study of atherosclerosis, CIMT was found to be a modestly better predictor of stroke, but it was a worse predictor of CHD than coronary artery calcium (CAC) score at a median follow-up of 3.9 years among 6698 adults asymptomatic at baseline. Paramsothy et al (2010), also reporting on the MESA trial, compared CIMT results in 4792 healthy individuals (nondiabetic adults not on lipid-lowering medications) across 6 different lipid groups, including normolipemia and several types of common dyslipidemias. Mean CIMT values were increased only for the combined hyperlipidemia (defined as any high-density lipoprotein cholesterol level, low-density lipoprotein cholesterol ≥ 160 mg/dL, and triglyceride ≥ 150 mg/dL) and simple hypercholesterolemia (defined as any high-density lipoprotein cholesterol level, low-density lipoprotein cholesterol ≥ 160 mg/dL, and triglyceride < 150 mg/dL) groups. Blaha et al (2011) published another MESA report assessing 6760 patients with elevated high-sensitivity C-reactive protein as defined by the justification for the Use of Statins in Primary Prevention: An Intervention Trial Evaluating Rosuvastatin study; (2011) they found CIMT increases correlated with obesity but only mildly with
high-sensitivity C-reactive protein. Patel et al (2015) also reported on the MESA trial, which evaluated 6125 individuals with a family history of premature CHD, and identified 382 atherosclerotic CVD events at a mean follow-up of 10.2 years. The study found that CAC data improved the risk estimation of atherosclerotic CVD events, but CIMT did not.

Camhi et al (2011) reported on the Bogalusa Heart Study (N = 991 subjects) and found that obesity along with overweight and elevated metabolic risk were associated with increased CIMT. They also reported that in this study population, 41% of patients had increased CHD risk. In an association between clotting factor VII and the carotid intima-media thickness study, clotting factor VII was associated with increases in CIMT in 1254 subjects. CIMT has also been used as a surrogate outcome measure in atherosclerosis treatment research studies. Baber et al (2015) reported on the BioImage study (2015), which enrolled 5808 asymptomatic individuals from the U.S. All patients were evaluated by 3-dimensional carotid ultrasound and by CAC score and followed for a median of 2.7 years. The primary endpoint was major cardiovascular events, defined as cardiovascular death, MI, and ischemic stroke. Carotid plaque burden was an independent predictor of outcomes, with an HR of 2.36 (95% CI, 1.13-4.92) for individuals in the highest tertile. The CAC score was also an independent predictor of outcomes, with HRs similar to carotid plaque. Both carotid plaque and CAC score led to significant net reclassification, with a net reclassification index of 0.23.

Geisel et al (2017) conducted a prospective cohort study of 3108 patients without CVD on entrance to the study. All patients were evaluated for traditional risk factors of CVD; they were also assessed to calculate the CIMT, CAC score, and Ankle-Brachial Index score. During a mean follow-up of 10 years, 223 individuals suffered a major cardiovascular event (coronary event, stroke, CV death). All 3 methods helped predict adverse cardiovascular events. While CIMT was found to be higher in those who experienced an adverse cardiovascular event (0.76) than those who did not (0.69), CIMT did not significantly improve the prediction of cardiac risk for patients with an intermediate Framingham Risk Score.

Villines et al (2017) prospectively assessed a cohort of 3801 African American patients free of CVD at baseline. Over a median follow-up of 9 years, there were 171 new cases of CVD and 339 deaths. The incidence of cardiovascular events correlated with changes in CIMT and participants in the highest CIMT quartile had the largest unadjusted incident rates of CVD for both men and women. However, risk reclassification improved only slightly when adding CIMT to a model that included only traditional risk factors for CVD.

Table 4. Summary of Key Prospective Cohort Clinical Validity Study Characteristics

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Population</th>
<th>Study Type</th>
<th>Country</th>
<th>Dates</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>van der Meer (2004)</td>
<td>Asymptomatic for CHD; ≥55 y</td>
<td>Cohort</td>
<td>EU</td>
<td>1990-1993</td>
<td>NR</td>
</tr>
<tr>
<td>Lorenz (2010)</td>
<td>Initially free of CVD</td>
<td>Retrospective</td>
<td>EU</td>
<td>NR</td>
<td>10 y</td>
</tr>
<tr>
<td>Geisel (2017)</td>
<td>Initially free of CVD</td>
<td>Prospective</td>
<td>EU</td>
<td>2000-2003</td>
<td>Mean 10.3 ± 2.8 y</td>
</tr>
</tbody>
</table>

CHD: coronary heart disease; CVD: cardiovascular disease; NR: not reported.
Section Summary: Clinically Valid
Evidence from a randomized controlled trial (RCT) and large, prospective cohort studies has established that CIMT is an independent risk factor for CAD. However, systematic reviews have shown that use of CIMT data to reclassify patients into clinically relevant categories is modest and may not be clinically important. The uncertainty concerning the ability to reclassify patients into clinically relevant categories limits the potential for CIMT to improve health outcomes.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from RCTs.

Johnson et al (2011) conducted a study in which 55 patients, aged ≥ 40 years with 1 or more CAD risk factors, received carotid ultrasound screenings to determine prospectively whether abnormal results would change physician and patient behaviors. Results were considered abnormal (when CIMT was > 75th percentile or with the presence of carotid plaque) in 266 patients. Self-reported questionnaires were completed before the carotid ultrasound, immediately after the ultrasound, and 30 days later to assess behavioral changes. Physician behavior in prescribing aspirin (P < .001) and cholesterol medication (P < .001) changed significantly after identification of abnormal carotid ultrasound results. Abnormal ultrasound results predicted reduced dietary sodium (odds ratio = 1.45; P = .002) and increased fiber intake (odds ratio = 1.55; P = .022) in patients, but no other significant changes. Health outcomes were not evaluated in this study, and the short-term follow-up limits interpretation of results.

Chain of Evidence
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

The evidence on the reclassification of cardiovascular risk offers a potential chain of evidence to improve outcomes. If a measure helps reclassify patients into risk categories that have different treatment approaches, then clinical management changes may occur that lead to improved outcomes. Because the ability to reclassify patients into clinically relevant categories with CIMT is modest at best, the clinical utility of this measure for reclassification is uncertain.

One study, however, aimed to estimate “normal” CIMT progression in order to identify subjects with faster atherosclerosis development. Olmastroni et al (2019) analyzed 1175 participants (36% men; mean age, 53 ± 11 years at baseline) with low to moderate cardiovascular risk. The participants underwent 4 clinical evaluations and ultrasound CIMT determinations approximately every 4 years. Investigators assessed the growth of CIMT for each participant across the 12 years of the study using growth curve modeling. Results showed age to be the major factor in the significant slope observed for both mean CIMT and maximum CIMT models (mean: β = 0.01, P < .001; maximum: β = 0.013, P < .001). Sex also affected mean and maximum CIMT, with higher levels in men (mean: β = -0.027, P < .001; maximum: β = -0.033, P < .001). In addition, the age-dependent growth patterns differed between men and women. For women, menopausal status affected slopes. Women who were in menopause at the start of the study or who went through menopause during the follow-up had mean and maximum CIMT slopes that were similar to men’s. Women with fertile status over the course of the study period progressed slowest. Other factors, such as smoking, systolic blood pressure, fasting glucose, and presence of carotid atherosclerosis, predicted speed of progression of both mean and maximum CIMT. The
investigators noted that different mean and maximum CIMT curve slopes were seen in participants developing both carotid wall thickening and focal carotid atherosclerosis compared with the other participants. The results of this study demonstrated that estimated standard CIMT curves could be a useful tool for determining cardiovascular risk in asymptomatic low to intermediate risk patients, allowing for earlier and more individualized preventive measures.

Section Summary: Clinically Useful
There is no direct evidence on the clinical utility of measuring CIMT for cardiac risk stratification. The available evidence on reclassification into clinically relevant categories does not indicate that use of CIMT will improve health outcomes. The objective of one study, however, was to define standard CIMT progression in low to moderate cardiovascular risk patients. Study results showed definite patterns related to various factors that could be used as a tool to earlier identify patients at increased cardiovascular risk.

Summary of Evidence
For individuals who are undergoing cardiac risk assessment who receive ultrasonic measurement of CIMT, the evidence includes a randomized controlled study, large cohort studies, case-control studies, and systematic reviews. Relevant outcomes are test accuracy and morbid events. Some studies have correlated increased CIMT with other commonly used markers for risk of coronary heart disease and with risk for future cardiovascular events. Lorenz et al (2012) found in their meta-analysis that CIMT was associated with increased cardiovascular events, although CIMT progression over time was not associated with increased cardiovascular event risk. Peters et al (2012) found that the added predictive value of CIMT was modest, and the ability to reclassify patients into clinically relevant categories was not demonstrated. The results from these reviews and other studies have demonstrated the predictive value of CIMT is uncertain and that the predictive ability for any level of population risk cannot be determined with precision. Also, available studies do not define how the use of CIMT in clinical practice improves outcomes.

There is no scientific literature that directly tests the hypothesis that measurement of CIMT results in improved patient outcomes and no specific guidance on how measurements of CIMT should be incorporated into risk assessment and risk management. Objective of one study, however, was to define "normal" CIMT progression in low to moderate cardiovascular risk patients. Study results showed definite patterns related to various factors that could be used as a tool to earlier identify patients at increased cardiovascular risk, but patient outcomes were not assessed. The evidence is insufficient to determine the effects of the technology on health outcomes.

Supplemental Information
Practice Guidelines and Position Statements

American College of Cardiology and American Heart Association
In 2013, the guidelines from the American College of Cardiology and the American Heart Association on the assessment of cardiovascular risk did not recommend carotid intima-media thickness (CIMT) measurement in routine risk assessment of a first atherosclerotic cardiovascular disease event (class III: no benefit; level of evidence: B). This differs from their 2010 joint guidelines for assessment of cardiovascular risk, which indicated CIMT might be reasonable for assessing cardiovascular risk in intermediate-risk asymptomatic adults.

American Association of Clinical Endocrinologists et al
In 2017, the American Association of Clinical Endocrinologists and American College of Endocrinology published guidelines stating that CIMT could be applied as a risk stratification tool in determining the need for more aggressive preventive strategies against cardiovascular disease (grade B; best evidence level 2) but not routinely.

American Society of Echocardiography
In 2008, the American Society of Echocardiography consensus statement, endorsed by the Society for Vascular Medicine, stated that CIMT is a feature of arterial wall aging "that is not synonymous with atherosclerosis, particularly in the absence of plaque." The statement recommended measurement of both CIMT and carotid plaque by ultrasound "for refining CVD [cardiovascular disease] risk assessment in patients at intermediate cardiovascular disease risk (Framingham Risk Score 6%-20%) without established CHD [coronary heart disease], peripheral arterial disease, cerebrovascular disease, diabetes mellitus, or abdominal aortic aneurysm." However, Society acknowledged that "More research is needed to determine whether improved risk prediction observed with CIMT or carotid plaque imaging translates into improved patient outcomes."

U.S. Preventive Services Task Force Recommendations
In 2009, the U.S. Prevention Services Task Force (USPSTF) published a systematic review of CIMT within the scope of a larger recommendation on the use of nontraditional risk factors in coronary heart disease risk assessment. The USPSTF could not draw conclusions on the applicability of CIMT to the intermediate-risk population at large outside the research setting. The USPSTF summary of recommendation specific to CIMT stated that: "... the current evidence is insufficient to assess the balance of benefits and harms of using ... [CIMT] ... to screen asymptomatic men and women with no history of CHD to prevent CHD events." The USPSTF identified the following research need: "The predictive value ... of carotid IMT... should be examined in conjunction with traditional Framingham risk factors for predicting CHD events and death."

In 2018, the USPSTF published a recommendation statement on using nontraditional risk factors to assess risk of cardiovascular disease; CIMT was not mentioned in this recommendation.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this review are listed in Table 5.

Table 5. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ongoing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NCT01849575</td>
<td>Direct VisualizAtion of Asymptomatic Atherosclerotic Disease for Optimum Cardiovascular Prevention. A Population Based Pragmatic Randomised Controlled Trial Within Västerbotten Intervention Programme (VIP) and Ordinary Care (VIPVIZA)</td>
<td>3200</td>
<td>Sep 2022</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

References


### Documentation for Clinical Review

- No records required

### Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

#### IE

The following services may be considered investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>0126T</td>
<td>Common carotid intima-media thickness (IMT) study for evaluation of atherosclerotic burden or coronary heart disease risk factor assessment</td>
</tr>
<tr>
<td></td>
<td>93895</td>
<td>Quantitative carotid intima media thickness and carotid atheroma evaluation, bilateral</td>
</tr>
<tr>
<td>HCPSC</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

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Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>12/07/2006</td>
<td>New Policy Adoption</td>
</tr>
<tr>
<td>04/02/2010</td>
<td>Policy revision without position change Coding update</td>
</tr>
<tr>
<td>08/06/2013</td>
<td>Policy revision without position change. Policy placed on No Further Routine Literature Review and Update status.</td>
</tr>
<tr>
<td>09/30/2014</td>
<td>Policy title change from Carotid Intima-Media Thickness Measurement Policy revision without position change</td>
</tr>
<tr>
<td>01/01/2015</td>
<td>Coding update</td>
</tr>
<tr>
<td>01/01/2017</td>
<td>Policy revision without position change</td>
</tr>
<tr>
<td>03/01/2017</td>
<td>Policy revision without position change</td>
</tr>
<tr>
<td>07/01/2018</td>
<td>Policy revision without position change</td>
</tr>
<tr>
<td>07/01/2019</td>
<td>Policy revision without position change</td>
</tr>
<tr>
<td>07/01/2020</td>
<td>Annual review. No change to policy statement. Literature review updated.</td>
</tr>
</tbody>
</table>

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member’s illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member’s health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.
Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.